II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible	None	None
Coinsurance After Deductible	None	None
Out-of-Pocket Maximum Individual Family	 $1,000 $2,000	 Not Covered Not Covered
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital, medical expenses and prescription benefits)	Unlimited	
Physician Office Visits and other eligible expenses in office	$10 copay	Not Covered
Allergy Injections received in a Physician's Office	$10 copay	Not Covered
Preventative Care Includes: Well baby and child care, routine physical, vision and hearing screenings, and immunization.	No Charge	No Charge
Hospital Daily Hospital Room and Board, Semi Private and other allowable expenses	No Charge	Not Covered
Professional Fees for Surgical and Medical Services	No Charge	Not Covered
Ambulance	No Charge	Not Covered
Emergency Care (Copay waived if admitted) Hospital ER	 $30 copay	 $30 copay
Urgent Care	$30 copay	$30 copay

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Mental and Nervous Expense Inpatient (Limited to 45 days per calendar year)	No Charge	Not Covered
Outpatient (2 sessions may be substituted for one day inpatient mental services)	$10 copay	Not Covered
Substance Abuse Inpatient (1 inpatient day may be substituted for 2 outpatient visits. 2 sessions of intermediate care, ie. partial hospitalization, may be substituted for 1 inpatient day)	No Charge	Not Covered
Outpatient (2 sessions of outpatient visits may be substituted for one day of inpatient services. 2 sessions of outpatient group therapy may be substituted for one outpatient visit)	$10 copay	Not Covered
Early Intervention Services	$10 copay	Not Covered
Infertility (Limited to 6 cycles for IVF-ET, ZIFT, GIFT and NORIF/NORIVF)	$10 copay	Not Covered
Hearing Aids (Limited to $2,500 per year. Limited to a single purchase every 3 years.)	No Charge	Not Covered
Outpatient Surgery, Diagnostic and Therapeutic Services (Includes: surgery, lab and radiology/ X-rays, mammography, pap smear, prostate screening, colorectal screening, chemotherapy or intravenous infusion therapy.	No Charge	Not Covered
Organ/Tissue Transplants	No Charge	Not Covered
Accidental Dental Services	25% coinsurance	Not Covered
Chiropractic (Limited to 24 visits per calendar year)	$10 copay	Not Covered
Home Health Care	No Charge	Not Covered

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Skilled Nursing Facility Care (Limited to 60 Inpatient days per calendar year)	No Charge	Not Covered
Hospice Care (Limited up to 360 days per lifetime)	No Charge	Not Covered
Durable Medical Equipment (Total rental not to exceed purchase price.)	20% coinsurance	Not Covered
External Prosthetic Devices -Wigs, toupees or hair pieces (Limited up to 2 per diagnosis/course of treatment. Does not cover for the diagnosis of androgenetic alopecia- male pattern baldness)	20% coinsurance, and any amount over $350 maximum	Not Covered
Prosthetic Devices (Includes: artificial limb, eye, and breast prosthesis. Limited to a single purchase of each type of prosthetic device every 3 calendar years. Benefits limited up to $2,500 per calendar year)	20% coinsurance	Not Covered
Rehabilitation Services-Outpatient Therapy Physical, occupational, and speech therapy (Limited to 60 visits combined per calendar year)	No Charge	Not Covered
Pulmonary rehabilitation therapy (Up to 20 visits per calendar year)	No Charge	Not Covered
Cardiac rehabilitation therapy (Up to 36 visits per calendar year)	No Charge	Not Covered
Routine Vision Exam (One exam every year)	Benefits are covered by VSP. See Separate Description.	

PRESCRIPTION DRUG BENEFITS	YOUR SHAREL OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Retail (30-Day Supply)		
Generic	$9	Not Covered
Brand Formulary	$18	Not Covered
Mail Order (90-Day Supply)		
Generic	$16	Not Covered
Brand Formulary	$32	Not Covered
Specialty Drugs	10% coinsurance	Not Covered

Dental Benefits
Provided by Delta Dental- call 1-800-452-9310 for Customer Service
1-800-335-8265 for Providers in your area.

You may also obtain information on their website at www.deltadentalnj.com

Vision Benefits
Provided by VSP- call 1-800-877-7195 for Customer Service

You may also obtain information on their website at www.vsp.com